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Mid-Atlantic Permanente Medical Group, P.C.
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc

Secretary Joshua M. Sharfstein
Chairman of the Maryland Health Benefit Exchange Board of Trustees
Department of Health and Mental Hygiene
Herbert R. O'Connor State Office Building
201 W. Preston St.
Baltimore, Maryland 21201

Ms. Rebecca Pearce
Executive Director
Maryland Health Benefit Exchange
4201 Patterson Avenue
Baltimore, Maryland 2121k

November 22, 2011

Re: Final Reports of the Maryland Health Benefit Exchange Advisory Committees

Dear Secretary Sharfstein and Ms. Pearce:

Thank you for the opportunity to provide comments on the final reports of the Maryland Health Benefit Exchange Advisory Committees. As you are aware, I have been an active participant on the Advisory Committee that focused on operations and insurance rules on behalf of Kaiser Permanente. We believe that the development of the Exchange is one of the most critical issues facing Maryland in moving towards assuring affordable coverage and quality health care services for individuals and small businesses. We support the Advisory Committee process that was implemented by the Exchange Board as a way to obtain constructive input from a broad cross section of Maryland stakeholders.

Kaiser Permanente of the Mid-Atlantic States region, headquartered in Rockville, Maryland, provides and coordinates complete health care services for almost 500,000 members through 30 medical office buildings in Maryland, Virginia, and Washington D.C. Established in 1980, Kaiser Permanente in Maryland is a total health organization composed of Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. and the Mid-Atlantic Permanente Medical Group, P.C., an independent medical group that features approximately 900 physicians who provide or arrange care for patients throughout the area.

As you may know, Kaiser Permanente operates in a number of regions outside of the Mid-Atlantic States area. Over the years, we have participated both in State-run and commercial Exchanges. Our comments here reflect some of that experience and history.

While a number of elements will contribute to success, we believe one core principle should be emphasized. The Exchange must be designed in the context of the broader market. This means that the market rules must be the same inside and outside the Exchange. Different rules will provide incentives to game one market or the other, and can provide the opportunity for adverse selection. We believe the Affordable Care Act (ACA) favors rules designed to prevent adverse risk selection, both against the Exchange and the outside market. Whether inside or outside the Exchange, Kaiser Permanente strongly believes the ACA was intended to encourage issuers to compete on factors such as quality, value and service, rather than on which company is best able to reduce its risk profile.

The Exchange will need to provide incentives to individuals and businesses to purchase and maintain coverage to assure a balanced risk pool and affordable coverage in the individual and small group markets. Thus, it will need to have a strong value proposition to make it an effective competitor and distribution channel in these markets. The Exchange should provide tools for individuals and employers to compare plans based on quality, service and price. The Exchange should increase transparency around the overall value of the plan products offered. Finally, the Exchange should promote payment and delivery reforms that will ultimately lead to more affordable, higher quality care. It is in this context that we offer the following comments.

1. Comments on Final Report: Operations and Insurance Rules Exchange Advisory Committee

A. The Exchange should act primarily as a managed market facilitator.

The Exchange Advisory Committee's report examines the conflicting views of whether the Exchange should exercise a high level of control over the issuers who participate, or simply facilitate a managed market. Kaiser Permanente believes that Exchanges will work best if the Board allows all qualified issuers to participate, and actively compete, in the Exchange.

We believe that the market facilitator approach, where all plans that meet established criteria are offered in the exchange, will allow a broader choice of plans and provider networks for consumers, and encourage issuers to innovate and compete on quality and cost. That innovation and competition will, in turn, flow into the outside market improving the affordability and quality of care for all of Maryland.

However, we also believe that the Exchange should make sure that the competitors are adequately prepared to compete in this market. Most importantly, all issuers must be able to show that the medical care they deliver meets well-developed, publicly reported quality standards. Clinical measures such as the Health Plan Employer Data and Information Set (HEDIS), and consumer satisfaction tools like the Consumer Assessment of Healthcare Providers and Systems (CAHPS) are now well recognized as industry standards, and the Exchange should assure that all issuers have satisfactory scores in order to participate. Because of this concern, we are comfortable with the model described in option 2 in the Advisory Committee's report.

Kaiser Permanente believes that the Exchange would be most successful if issuers are not mandated to participate, but make a business choice that participation in this new marketplace

will be beneficial. The Exchange should view itself as needing to make efforts to attract issuers. If the Exchange is required to operate in a manner that is attractive to issuers, it is more likely to effectively compete with the outside market.

B. Qualified Dental Plans should be offered on the Exchange.
Kaiser Permanente supports rules allowing dental coverage to be offered in the Exchange both as a stand-alone and bundled offering. Following purchase of medical coverage that includes the required essential pediatric dental services, consumers should be given the option to add dental coverage to their total health plan. Exchanges should provide incentives to plans with the ability to bundle both medical and dental coverage. The synergy produced through bundled medical and dental coverage ultimately leads to increased administrative ease and better total health.

C. Adverse Selection can be addressed with a comprehensive strategy.
Adverse selection is one of the most pervasive issues the Exchange will have to guard against. Kaiser Permanente strongly agrees with the Committee's in-depth discussion about the importance of enacting uniform market rules, applicable inside and outside the Exchange as a key strategy to avoid adverse selection against either market.

Imposition of stricter or different rules for benefit plans offered within the Exchange will undercut affordability and the competitive attractiveness of the Exchange and increase the cost of administration within the Exchange. Conversely, stricter rules for issuers operating outside the Exchange will erode the outside market, which the ACA clearly intended to remain in place. We believe that state law and regulation should apply uniformly to benefit packages offered in and outside the Exchange.

This uniformity should apply to the design of Qualified Health Plans (QHPs). Standardized benefit packages that allow consumers to easily compare the package based on quality and price, rather than benefit design, would encourage issuers to compete on quality of care and price, rather than risk selection achieved through benefit design. That is one of the biggest problems with the current market that the ACA is trying to address. We strongly support the adoption of standardized, uniform benefit packages.

The Maryland Exchange Act requires any issuer participating in the Exchange to offer a benefit plan outside of the Exchange that is equivalent to the silver and gold plan offered inside the Exchange. We urge Maryland to take the next logical and necessary step as well. We strongly recommend that an issuer be prohibited from offering catastrophic coverage outside of the Exchange unless that issuer participates in the Exchange. Again, this would help to prevent issuers from attracting low risk people away from the Exchange, and basing their market model on risk selection rather than quality, value and service.

The ACA provides three specific tools to help address the problem of adverse selection – reinsurance, risk adjustment and risk corridors - which cannot be viewed in isolation. Kaiser Permanente believes they must be deployed in conjunction with one another, and coordinated with a fourth tool: the Medical Loss Ratio (Because of the complicated interaction of the MLR with the other three tools, Kaiser Permanente has asked CCIIO to delay implementation of the MLR until the results of the first three risk management strategies can be properly determined).

Designed appropriately, a comprehensive risk mitigation strategy will help stabilize the market in the short term and create new incentives for enrolling and managing the care of the chronically ill over the long term. It is important to note that risk adjustment cannot solve the issue of adverse selection alone. It needs to be adopted in conjunction with a properly designed market.

Kaiser Permanente recommends that Maryland wait for the release of the federal risk adjustment model, then evaluate whether it would adequately serve the needs of the Maryland Exchange. We agree with the opinion expressed in the Committee that there are too many unknowns to effectively develop a risk adjustment mechanism for Maryland. At this point, resources are best used to establish the Exchange. A Maryland specific risk adjustment model could be developed at a later point, if necessary.

D. Maryland Should Not Establish a Basic Health Program Unless Very High Standards Are Met.

Major features of the ACA are designed to reduce the number of uninsured, increase access to affordable coverage, and increase transparency about benefits, coverage, pricing, and quality. Exchanges are a fundamental mechanism contributing to success regarding these important goals of reform. Kaiser Permanente is concerned that implementation of a Basic Health Program (BHP) in Maryland without more deliberation and a greater understanding of the design of the essential health benefit packages and their cost could threaten the Exchange's viability and weaken important market reforms by exacerbating cost shifts to the private sector and further complicating health care financing.

We recommend that Maryland not establish a Basic Health Program unless very high standards are met with respect to:

- *The stability of the Exchange marketplace*. Success of Exchanges will rely on a large pool of consumers in a competitive marketplace with high quality, affordable health coverage offered by numerous plans. According to some estimates, a BHP will remove as much as one-half of consumers from Exchange enrollment and will shift up to 70% of low-income subsidy funding from the Exchange to the BHP. The Wakely Consultant Group, in a report dated November 7, advised the Finance Committee that absent any material population differences between the BHP-eligible population and the remainder of the Exchange population, reducing the scale of membership in the Exchange will increase the per-member cost as well as administrative costs as a percentage of premiums for covered individuals. Implementing a BHP could place a strain on the Exchange's sustainability.
- *Assurances that cost shifts will not be exacerbated with respect to other payers.* Low BHP payment rates, paired with major Medicaid expansions, will exacerbate cost shifts to commercial payers, undercutting one of the goals of ACA, to increase the affordability of coverage to individuals and businesses.
- *Health care financing that is streamlined and not further fragmented*. The ACA seeks to facilitate the cooperation and integration of providers so that patient care can be more easily and cost-effectively coordinated and improved. Health financing should also reflect this move toward integration and streamlining, not toward fragmentation and administrative complexity. We suggest the Exchange Board assess if new state BHP programs, with different rules and financing streams, further complicate or improve health care delivery.

The risk of undercutting the Exchange together with the risk of insufficient federal funding for the BHP should result in Maryland being very cautious about implementation of a BHP.

2. Comments on Small Business Health Options Program (SHOP) Advisory Committee Final Report

Kaiser Permanente strongly supports the establishment of a SHOP Exchange. As an active participant in private exchanges serving small employers, we know that a properly designed Exchange can offer small employers significant savings in administration, increased choice of plans for their employees, and can help drive improvements in the quality and affordability of the care provided. We further support the SHOP Exchange focusing on the small group market (50 employees and under), at least until 2017.

A. Employee Choice within the SHOP Exchange

We strongly support a provision that would require the SHOP Exchange to allow employees to choose from any QHP offered within a metal level selected by a qualified employer. A major shortcoming of the small group market today is that small employers generally can offer only a single carrier to their employees. The major advantage and value offered by a SHOP Exchange is to remove the burden on small employers to have to make such choices, and to serve as a clearinghouse so that employee choice in this critical area is maximized, and employer involvement is minimized. The importance of this choice for individual employees is highlighted when thinking about how important providers are to each of us. Currently, when an employer chooses coverage for employees, the employer is also choosing the employees' providers. This not only puts the employer in the way of developing provider-patient relationships and continuity of care, it can also affect employee morale. Exchanges will be more attractive to both employers and their employees if individual employees are permitted to choose their own QHP, and (consequently) their own providers.

This kind of individual choice will reduce the administrative burden on the employer and relieve the employer of selecting a QHP that may not be optimal for all its employees. Finally, yet equally important, employee choice will support the development of integrated health care delivery systems that operate in partnership with QHPs by allowing employees to pick their own providers and maintain them over time. Failure to allow employee choice preserves the currently dysfunctional market where employers more often than not have a strong incentive to force employees to change their provider networks. This undercuts the stability of high-performing, team-based provider networks. We believe that it is vital to adopt employee choice as soon as an Exchange becomes operational to promote this primary value of the Exchange to consumers.

We also strongly oppose a provision that would allow an Exchange to design "subscriber choice" to allow an employer to require an employee purchasing coverage through the SHOP to choose a QHP offered by a specific issuer, either within a specific metal level or offered at any metal level by that issuer. Again, this defeats the primary purpose of the ACA of allowing consumers as much choice as possible. As important, such an approach is not authorized under the ACA. The specific language of Section 1312(a)(2) requires that employees be able to choose any QHP within the level specified by the small employer. Section 1312(f)(2)(B) applies only to large

employers, if a state permits large employers into the Exchange beginning in 2017, and does not authorize small employers to choose anything other than the level of coverage.

B. Employees should have the choice to "buy up" one metal level beyond what their employer will offer.

We support allowing employees to "buy up" one metal level above the metal level chosen by the employer. An employee who is willing to bear the additional cost of more comprehensive coverage should be allowed that option. This balances two important factors. Employers need to have predictable costs that they have some control over. However, employees, who are (in this context) also consumers, should not be entirely limited by that business reality.

It should be recognized, however, that this additional degree of choice will result in some additional cost due to the well-established tendency of individuals to self-select cost-sharing amounts based on their expected use of services. If the buy up is limited to one metal level, we believe these costs will be modest, and also manageable by the Exchange, although the option places an additional burden on risk adjustment mechanisms and may require the Exchange to use other administrative strategies to keep premiums competitive with the outside market. We also recommend that employees have a choice of any carrier in a specified metal level.

Conclusion

Kaiser Permanente sees a tremendous opportunity for the Maryland Exchange to provide quality, affordable choices to individual consumers and small employers and we thank you for the opportunity to comment on the final reports of the Advisory Committees. Please feel free to contact me at 301-816-6440 to arrange further discussion or if you have any questions. We look forward to working with you on these issues.

Sincerely,

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